SECTION 3 **MEDICAID PROVIDER INFORMATION**

Qualifications for Enrollment

The general requirements for provider enrollment are as follows:

Licensure – Providers must be licensed, accredited, and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but most providers must complete an application and a North Carolina participation agreement. All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider. For detailed information regarding specific requirements for each provider type, refer to DMA's Web site at http://www.dhhs.state.nc.us/dma/provenroll.htm or call DMA Provider Services at 919-855-4050.

Service Location – Services must be provided at a site location in North Carolina or within 40 miles of the North Carolina border. Out-of-state providers beyond 40 miles of the North Carolina border may enroll in the N.C. Medicaid program to provide emergency or prior approved services only. Providers must bill using their site-specific provider numbers.

Provider Agreements – Providers sign participation agreements with DMA. These agreements contain general requirements for all providers as well as specific requirements for each service type.

All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up to date. Refer to **Reporting Provider Changes** on page 3-5 for information on reporting changes in provider status to the Medicaid program.

Enrollment Procedure

Providers who wish to enroll must complete an application and agreement for the specific provider type. Applications and agreements are located are on DMA's Web site at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Once an application packet is received and processed by DMA, providers are assigned provider numbers and are notified by mail once the enrollment process has been completed. Processing times vary according to provider type. The Provider Enrollment staff research the Office of Inspector General sanctions, Senate Bill 926, appropriate medical board databases and other sources for verification that a provider is in good standing prior to enrollment. Providers are referred to DMA's Web site at http://www.dhhs.state.nc.us/dma/prov.htm for Medicaid service information.

Tax Information

To ensure that 1099 MISC forms are issued to providers correctly, proper tax information must be on file for all providers. This will also ensure that the correct tax information is provided to the IRS.

Independent practitioners such as physicians, dentists, nurse practitioners, etc., are assigned individual attending Medicaid provider numbers. Most often, these numbers are linked to the provider's SSN. When an independent practitioner provides services in a group setting, the group provider number is indicated on the claim form along with the individual provider number. The claim will pay to the group number and report to the group tax identification number. Individual providers should not link their individual provider numbers to group tax identification numbers.

The last page of the RA indicates the provider tax name and number (FEIN) that Medicaid has on file. Review the RA throughout the year to ensure that the correct provider number information is on file with EDS. The tax information needed for a group practice is as follows:

- Group tax name and group tax number
- Attending Medicaid provider numbers in the group

Providers may also verify the tax information by calling EDS Provider Services at 1-800-688-6696 or 919-851-8888.

The procedure for submitting corrected tax information to the Medicaid program is as follows:

- All providers must submit completed and signed W-9 forms along with a completed and signed Provider Change Form to Medicaid at the following address:
  Division of Medical Assistance
  Provider Services
  2501 Mail Service Center
  Raleigh, NC 27699-2501

Providers must also report changes of ownership and practice group changes. For more information, refer to **Reporting Provider Changes** on page 3-5.

Conditions of Participation

Civil Rights Act

Providers must comply with Title VI of the Civil Rights Act of 1964, which states "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving Federal financial assistance."

Rehabilitation and Disabilities Acts

In addition to the laws specifically pertaining to Medicaid, providers must comply with the following requirements:

- **Section 504 of the Rehabilitation Act of 1973**, as amended, which states "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance."
- **The Age Discrimination Act of 1975,** as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."

- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

Disclosure of Medicaid Information

The provider must comply with the requirements of the Social Security Act and federal regulation concerning:

- The disclosure of ownership and control information by providers (other than an individual practitioner)
- The disclosure of any felony convictions by a provider or any owners
- The disclosure of any disciplinary action taken against business or professional licensees by a provider
- The disclosure of any denial of enrollment, suspension or exclusion from Medicare or Medicaid in any state or employment by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state
- The disclosure regarding any suspended payments from Medicare or Medicaid in any state or employment by a corporation, business or professional association that ever had any suspended payments from Medicare or Medicaid in any state.

Medical Record Documentation

As a condition of participation, Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program. Records must be retained for a period of not less than six years from the date of service unless a longer retention period is required by applicable federal or state law, regulations or agreements. Copies of records must be furnished upon request. HIPAA does not prohibit the release of records to Medicaid. Record documentation is used by DMA to determine medical necessity and to verify that services were billed correctly.

The following principles of documentation are adopted from Medicare policy:

1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessment; clinical impression or diagnosis; services delivered; plan for care including drugs and dosage prescribed or administered; and legible signature of the observer.
3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.
4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.
5. The patient's progress, including response to and change in treatment, must be documented. Reasons for diagnostic revision must be documented.
6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

Payment in Full

With the exception of authorized co-payments by recipients, the provider must agree to accept the amount paid for Medicaid-covered services as payment in full. This requirement is in accordance with the rules and regulations for reimbursement promulgated by the Secretary of DHHS and by the State of North Carolina and established under the Medicaid program.

Fee Schedule Requests

There is no charge for fee schedules or reimbursement plans requested from DMA. The information that is provided is to be used only for internal analysis. Providers must bill their usual and customary rate. Requests for fee schedules and reimbursement plans must be made on the Fee Schedule Request form (see Appendix G-3) and mailed to the address listed on the form. The Fee Schedule Request form may also be faxed to DMA's Finance Management section at 919-715-2209. Telephone requests are not accepted.

Many of the fee schedules are also available on DMA's Web site at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

Provider Responsibilities

Verifying Recipient Eligibility

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. Refer to Verifying Eligibility on page 2-12 for additional information.

Billing the Recipient

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

A provider may also bill a Medicaid recipient for the following:

- Payments for services that are made to the recipient and not the provider by either commercial insurance or Medicare.
- Services not covered by Medicare if the recipient has Medicare-AID (MQB-Q) coverage. (MQB-Q recipients receive a buff MEDICARE-AID card.)
- Allowable Medicaid deductibles or co-payments.*
- Prescriptions in excess of the eleven per month limit unless recipient is locked into their pharmacy of record.*
- Visits in excess of the 24 visit limit for provider visits for the state fiscal year (July 1-June 30).*

- The recipient's failure to provide proof of eligibility by presenting a current MID card.
- The recipient's loss of eligibility for Medicaid as defined in 10 A NCAC 21B.
- The portion of psychiatric services for a Medicare-eligible recipient that are subject to the 37.5% psychiatric reduction in Medicare reimbursement.

***Note:** For recipients under the age of 21 and EPSDT requirements, see Section 2 of this manual.

Third Party Liability

State and federal regulations for Third Party Liability (TPL) require responsible third party insurance carriers to pay for medical services prior to a provider submitting a claim to Medicaid. Providers are required to seek payment from third party insurance carriers when they know of their existence. A third party insurance carrier is an individual or company who is responsible for the payment of medical services. These third parties are Medicare, private health insurance, automobile, or other liability carriers. DMA's third party recovery (TPR) unit is responsible for implementing and enforcing TPL laws. The TPR unit implements and enforces these laws through both cost avoidance and recovery methods. Refer to the **Third Party Liability Section** on page 7-2 for additional information.

Overpayments

The PI section of DMA conducts regular post-payment reviews in an ongoing effort to:

- Determine a statistical payment accuracy rate for claims submitted by providers and paid by Medicaid.
- Ensure that Medicaid payments are made only for services that are covered under Medicaid policy
- Verify that coding on Medicaid claims correctly reflects the services that were provided.
- Ensure that third party carriers are billed before Medicaid was billed and that providers reported any such payments from third parties on claims filed for Medicaid payment.

When overpayments are identified, providers are given written information about the errors and are required to refund the overpayment amount.

Reporting Provider Changes

What Changes Must Be Reported

All providers are required to report all changes in status to Medicaid. This includes changes of ownership (within 30 days), name, address, tax identification number, licensure status, and the addition or deletion of group members.

Managed care providers [Carolina ACCESS (CCNC), ACCESS II/III, and PCHP] must also report changes in daytime or after-hours telephone numbers, counties served, enrollment restrictions, etc. CCNC providers must report Medicaid provider number changes immediately to ensure that CCNC management fees are paid correctly.

Failure to report changes in provider status may result in suspension of the Medicaid provider number and a delay in your receipt of claims reimbursement. In addition, providers may be liable for taxes on income not received by their business.

How to Report a Change

Refer to the back of the **Medicaid Provider Change Form** in Appendix G-5 to determine the appropriate process for reporting changes in provider status according to your specific provider type. Carolina ACCESS (CCNC) providers and ACCESS II/III providers must also report changes using the **Carolina ACCESS Provider Information Change Form** in Appendix G-6. Both forms are also available on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Voluntary Termination

All providers must notify DMA in writing at the address listed below of their decision to terminate their participation in the N.C. Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager or administrator.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Managed care providers must also notify additional parties to request termination:

- Carolina Access (CCNC) and ACCESS II/III providers must send DMA Provider Services (at the address above) a completed Carolina ACCESS Provider Information Change Form requesting termination from the program. This must be addressed to DMA Provider Services at the above address.

- PCHP must notify DMA's managed care section of their decision to terminate. Refer to page 4-7 for additional information.

Termination of Inactive Providers

If an enrolled Medicaid provider does not bill Medicaid within 12 months, DMA will send notice of termination of the Medicaid provider number. These notices are sent to the current mailing address listed in the provider's file. A provider who wishes to remain enrolled as a Medicaid provider will have two weeks to respond with a justification. Once terminated, providers must complete a new application and agreement to re-enroll and may have a lapse in eligibility as Medicaid providers.

Payment Suspension

If RAs and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the

address has not been corrected, claims in suspension will be denied and the provider number will be terminated.

Licensure Revocation or Suspension

Any provider or facility whose license is revoked or suspended is not eligible for participation in the N.C. Medicaid program. Providers whose licenses are revoked or suspended should notify DMA immediately.

Reactivation in the Medicaid program may occur when the license is reinstated by the licensing authority. Reactivation must be requested in writing by the provider or the facility. A copy of the reactivated license must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

Providers who receive one or more sanctions from CMS may become ineligible for Medicaid participation and may be responsible for refunding any Medicaid payments made to them while under CMS sanctions. CMS will notify DMA of providers who are sanctioned. Any provider who is sanctioned should notify DMA immediately.

Program Integrity Reviews

Determining Areas for Review

PI reviews are initiated for a variety of reasons. The following are examples of reviews conducted by PI:

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies or other DMA sections.
- PI uses a Fraud and Abuse Detection System (FADS), which consists of two software products called HealthSPOTLIGHT and OmniAlert.
    - HealthSPOTLIGHT uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraud and abuse claims.
    - OmniAlert is PI's client server Surveillance and Utilization Review System (SURS). OmniAlert is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
    - Additional features such as claims imaging, the claims data warehouse, and ad hoc query tools along with FADS software also make detection and investigation faster.
    - Special ad-hoc DRIVE computer reports that target specific issues, procedure codes or duplications or services, etc.
- The Office of the State Auditor pulls a stratified sample of claims annually. PI staff review these claims to determine the payment accuracy rate for claims submitted by providers and paid by the Medicaid MMIS+ system.
- PI staff also conduct a second sampling of provider billings using methodology prescribed by CMS. This is to assist CMS in complying with HR 4878, the Improper Payments Act of 2002.
- DMA is also participating as a pilot state in a national project called Medi-Medi. In this project, Medicare and Medicaid claims are stored in a combined data warehouse. The data is then mined to identify possible fraud and abuse.

- EDS refers questionable services in identified during claims processing to PI.

Provider Responsibilities in a Program Integrity Review

If you are notified that PI has initiated a review, you should adhere to the following steps:

- PI will request medical and/or financial records either by mail or in person. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.
- If you receive a recoupment letter from PI, review the information in the letter and chart. You have two options:
  - If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. Please send your check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS as this could result in a duplication of your refund. Also, do NOT request that EDS adjust for the amount or items identified, as this could result in duplicate recoupment.
  - If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form to the DHHS Hearing Unit at the address on the letter and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Request for Reconsideration

Informal Hearings – A provider who disagrees with a DMA decision may have the right to an informal hearing. If applicable, the provider will be notified of the right to an informal hearing, conducted in Raleigh. The DHHS Hearing Office will notify the provider of the date, time, and location.

Paper Reviews – You may instead send any additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Miscellaneous

- For assistance or information, please call EDS at 1-800-688-6696 or 919-851-8888.
- It is the provider's responsibility to maintain the medical coverage policies and Medicaid bulletins and to ensure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to and follow these Medicaid guidelines.

Self-Referral Federal Regulation

For Medicaid payments, the omnibus Budget Reconcilliation Act of 1993 (OBRA 1993) prohibits self-referral by a physician to designated health services in which the physician has certain ownership or compensation agreements. Designated health services include the following:

- Clinical laboratory services

- Outpatient drugs
- Durable medical equipment
- Parenteral and enteral nutrition equipment and supplies
- Comprehensive outpatient rehabilitation facility services
- Contact lenses
- Physical and occupational therapy services
- Home infusion therapy services
- Prosthetic and orthotic devices
- Eyeglasses
- Radiation therapy services
- Inpatient and outpatient hospital services
- Radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services)
- Hearing aids
- Home dialysis
- Home health services
- Ambulance services

If post-payment review determines that inappropriate payments were made due to the provider's failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in Section 1877 of the Social Security Act.

Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Discrimination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (for example, a living will or health care power of attorney).

NCGS 122C-71 – 122C-77, "An Act to Establish Advance Instruction for Mental Health Treatment," became effective January 1, 1998. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (that is, lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record. In conjunction with an advisory panel, DMA has developed *Medical Care Decisions and Advance Directives: What You Should Know* , the required summary of state law concerning patients' rights that must be distributed by providers. A copy is available in Appendix G-8,9.

The two-page brochure can be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Indicate in the box on the last page a contact for the patient to obtain more information. The brochure should be copied as is. If providers choose to alter the document graphically, they may not change or delete text, or the order of the paragraphs. A provider-published pamphlet must include the N.C. DHHS logo and production statement on page four of the folded brochure. A print-ready copy can be found on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html#prov.

Provider Information – Commonly Asked Questions

1. What are the requirements for enrollment in the N.C. Medicaid program?
Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Providers must complete an application and agreement and provide verification of licensure, if applicable. Refer to the DMA website at: http://www.dhhs.state.nc.us/dma/provenroll.htm for specific credentialing requirements.

2. Where can I get an enrollment application?
Applications for enrollment as a Medicaid provider are available from DMA Provider Services on our website at: http://www.dhhs.state.nc.us/dma/provenroll.htm. Written requests may be sent to the address below:
Division of Medical Assistance
Provider Services
2501 mail service center
Raleigh NC 27699-2501

3. How do I enroll as a managed care provider?

- Applications for participation as a Carolina ACCESS (CCNC) provider are available from DMA's Web site at http://www.dhhs.state.nc.us/dma/provenroll.htm
- To enroll as an ACCESS II/III provider, contact the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.
- To enroll as a Piedmont Cardinal Health Plan (PCHP) provider, contact Piedmont Provider Relations at 1-800-958-5596.

For additional information, contact DMA Provider Services at 919-855-4050 or the managed care consultant for your county.

4. How are group provider numbers assigned?
Group provider numbers are assigned to each physical site that delivers services to Medicaid recipients. If a group practice has 10 sites, each site must have a separate provider number. Individual providers are not issued separate numbers if they practice at more than one site; their individual provider numbers can be linked to several groups or from one group to another. Groups must notify DMA when an individual practitioner is added or deleted from their group practice.

5. When can I begin billing for services that I have rendered to Medicaid recipients?
Prospective Medicaid providers must apply for and be enrolled in the Medicaid program, assigned a provider number, and agree to certain conditions of participation before payment can be made for services rendered to Medicaid recipients. The effective date on the participation agreement is the earliest date a provider may begin billing for services.

6. **How often do I have to re-enroll as a Medicaid provider?**
Enrollment periods vary according to service types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting DMA Provider Services at 919-855-4050.

All providers are responsible for maintaining the required licensure and accreditation specific to their provider types to remain qualified as N.C. Medicaid providers.

All providers are responsible for ensuring that their service and facility information on file with N.C. Medicaid remains up to date.

7. Is it necessary for a physician who already has a Medicaid provider number to notify DMA if s/he transfers to a new practice?
Yes. While re-enrollment is not necessary, the physician must notify DMA that s/he is no longer linked to the old group practice and ask to be linked to the new group practice. The new group must complete the Provider Change form located on DMA's Web site. A physician will usually keep the same individual provider number. If billing under a group provider number, the group may begin billing for the new physician as long as the physician's individual provider number is active.

8. Are we required to apply for a new provider number if our group merges with another group and our group tax ID number changes?
Yes. A provider must apply for a new group provider number but the provider's individual provider number will remain the same. If you are merging groups but will still have separate locations, each office site must apply for a new group provider number.

9. Are individual providers required to apply for a new provider number if there is a change to the tax ID number?
No. But providers must notify the Medicaid program of the tax ID number changes.

10. If I have an individual provider number and I leave a group practice, do I need to change my tax ID number to the new group's tax ID number?
No. An individual provider number belongs to the individual provider. The provider's SSN or the FEIN tax number should not be changed when an individual provider leaves a group practice. When the provider joins a group and renders services, the group provider number must go in block 33 of the CMS-1500 claim form under "Grp". The individual provider number of the provider who rendered the service must go in block 33 under "PIN." The payment will be made to the group and reported under the group's tax ID number.

11. How do I contact the Medicaid program to report changes to my provider status?
The Provider Change form is located on our Web site at http://www.dhhs.state.nc.us/dma/forms.html#prov. Refer to **How to Report a Change** on page 3-6 for information on reporting changes in your provider status to the Medicaid program.

12. I am currently a Carolina ACCESS provider and my Medicaid provider number has changed. How do I report this change?
Changes must be reported to DMA Provider Services using the C**arolina ACCESS Provider Information Change form on our Web site at http://www.dhhs.state.nc.us/dma/forms.html#ca.**

If the Medicaid provider number that is changing is also your Carolina ACCESS (CCNC) provider number, DMA Provider Services must be alerted as soon as possible to ensure that the Carolina ACCESS (CCNC) management fee is paid correctly and to prevent claim denials. Until you receive notification that your CCNC number has been changed, claims filed using your new Medicaid provider number must also include your old Medicaid provider number (current CCNC number) in block 19 of the CMS-1500 claim form. It is imperative that you use your active CCNC number when you refer patients.

13. If our practice is participating as a provider in the Carolina ACCESS or ACCESS II/III program, whom do I contact when there is a change in our practice's provider number?

CCNC providers must report all changes to DMA Provider Services using the Carolina ACCESS Provider Information Change form on our Web site at http://www.dhhs.state.nc.us/dma/forms.html#ca. When reporting a change in ownership, CCNC providers must submit a new Carolina ACCESS enrollment application package. All providers must report changes to DMA using the Medicaid Provider Change Form (see Appendix G-4).

14. My organization participates with the Medicaid program as an administrative entity for ACCESS II/III. Who do I contact when there is a change in our provider status?

Report changes to the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.

15. I am currently enrolled as a Community Alternatives Program (CAP) provider. How do I amend my enrollment to include additional services?

CAP providers who are currently enrolled in the Medicaid program must send a completed enrollment application and verification of appropriate licensure and certification to DMA Provider Services at the address listed below. However, it is not necessary to complete a new agreement. Applications may be obtained from DMA Provider Services at the address listed below or on DMA's Web site at http://www.dhhs.state.nc.us/dmaa/provenroll.htm.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

16. My specialty is listed incorrectly. How do I correct it?

Requests to change a provider's specialty must be submitted in writing to DMA Provider Services at the address listed below. Requests must be written on letterhead and include the provider number and the correct specialty.

Division of Medial Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

19. How do I terminate my enrollment as a Medicaid provider?

Providers must notify DMA Provider Services in writing at the address listed below of their decision to terminate their participation in the Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

20. How do I terminate my enrollment as a Managed Care provider?
Managed Care providers [Carolina ACCESS (CCNC), ACCESS II/III] must notify DMA Provider Services, in writing, of their decision to terminate their participation in the managed care program, and must do so at least 30 days in advance of the effective date. Notification must be sent by registered mail with return receipt request to the address listed below.
Division of Medical Assistance
Provider Services
801 Ruggles Drive
Raleigh, NC 27699-2501

21. My practice has opened another location. Can I use their current group number?
No. You must enroll with one group number per site location. This applies to both Medicaid and Carolina ACCESS (CCNC) programs.